		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023093

Facility Name: BALLARD NURSING CENTER

Address: 9300 BALLARD ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: 847 294-2300 **Fax #** 847 827-0981

IDPA ID Number: 36-2897326

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARK PICK
(Title) VICE-PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			10,894	10,894	8
9	SNF/PED					9
10	ICF	26,911	8,148	4,165	39,224	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,911	8,148	15,059	50,118	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.44%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 10,894

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	260,533	27,530	7,850	295,913		295,913		295,913			1
2	Food Purchase		196,527		196,527		196,527	(3,078)	193,449			2
3	Housekeeping	214,124	43,566		257,690		257,690		257,690			3
4	Laundry	79,797	29,248		109,045		109,045		109,045			4
5	Heat and Other Utilities			199,948	199,948		199,948		199,948			5
6	Maintenance	85,650		81,474	167,124		167,124		167,124			6
7	Other (specify):*			26,783	26,783		26,783		26,783			7
8	**TOTAL General Services**	640,104	296,871	316,055	1,253,030		1,253,030	(3,078)	1,249,952			8
	B. Health Care and Programs											
9	Medical Director			81,100	81,100		81,100		81,100			9
10	Nursing and Medical Records	2,777,039	142,127	449,643	3,368,809		3,368,809		3,368,809			10
10a	Therapy	1,018,951	5,197	57,948	1,082,096		1,082,096		1,082,096			10a
11	Activities	137,732	9,880	1,170	148,782		148,782		148,782			11
12	Social Services	91,564		6,753	98,317		98,317		98,317			12
13	Nurse Aide Training											13
14	Program Transportation			14,326	14,326		14,326		14,326			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,025,286	157,204	610,940	4,793,430		4,793,430		4,793,430			16
	C. General Administration											
17	Administrative	112,984		158,500	271,484		271,484	(24,385)	247,099			17
18	Directors Fees											18
19	Professional Services			86,939	86,939		86,939	3,055	89,994			19
20	Dues, Fees, Subscriptions & Promotions			101,421	101,421		101,421	(53,047)	48,374			20
21	Clerical & General Office Expenses	541,330	78,603	119,907	739,840		739,840	(18,191)	721,649			21
22	Employee Benefits & Payroll Taxes			712,320	712,320		712,320	(1,716)	710,604			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,246	15,246		15,246		15,246			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			146,624	146,624		146,624		146,624			26
27	Other (specify):*			22,142	22,142		22,142	(10,106)	12,036			27
28	**TOTAL General Administration**	654,314	78,603	1,363,099	2,096,016		2,096,016	(104,390)	1,991,626			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,319,704	532,678	2,290,094	8,142,476		8,142,476	(107,468)	8,035,008			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BALLARD NURSING CENTER #0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,754	21,754		21,754	462,058	483,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,522	84,522		84,522	672,922	757,444			32
33	Real Estate Taxes							331,999	331,999			33
34	Rent-Facility & Grounds			1,272,000	1,272,000		1,272,000	(1,272,000)				34
35	Rent-Equipment & Vehicles			30,229	30,229		30,229		30,229			35
36	Other (specify):* Loan Amortizatn			34,352	34,352		34,352		34,352			36
37	**TOTAL Ownership**			1,442,857	1,442,857		1,442,857	194,979	1,637,836			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		437,301	536,547	973,848		973,848		973,848			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		437,301	663,020	1,100,321		1,100,321		1,100,321			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,319,704	969,979	4,395,971	10,685,654		10,685,654	87,511	10,773,165			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,146)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	55,922	30		9
10	Interest and Other Investment Income	(6,123)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(932)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(1,018)	21		18
19	Entertainment		20		19
20	Contributions	(8,170)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers	(4,912)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,142)	27		24
25	Fund Raising, Advertising and Promotional	(44,627)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(17,217)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,331)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	140,842		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 140,842		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 87,511		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARIES	(17,217)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(17,217)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,078)	0	0	0	0	0	0	0	0	0	0	(3,078)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,078)	0	0	0	0	0	0	0	0	0	0	(3,078)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(24,385)	0	0	0	0	0	0	0	0	(24,385)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,912)	7,000	967	0	0	0	0	0	0	0	0	3,055	19
20	Fees, Subscriptions & Promotions	(53,047)	0	0	0	0	0	0	0	0	0	0	(53,047)	20
21	Clerical & General Office Expenses	(18,235)	0	44	0	0	0	0	0	0	0	0	(18,191)	21
22	Employee Benefits & Payroll Taxes	(1,716)	0	0	0	0	0	0	0	0	0	0	(1,716)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(22,142)	0	12,036	0	0	0	0	0	0	0	0	(10,106)	27
28	**TOTAL General Administration**	(100,052)	7,000	(11,338)	0	0	0	0	0	0	0	0	(104,390)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(103,130)	7,000	(11,338)	0	0	0	0	0	0	0	0	(107,468)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	55,922	404,880	1,256	0	0	0	0	0	0	0	0	462,058	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,123)	679,045	0	0	0	0	0	0	0	0	0	672,922	32
33	Real Estate Taxes	0	331,999	0	0	0	0	0	0	0	0	0	331,999	33
34	Rent-Facility & Grounds	0	(1,272,000)	0	0	0	0	0	0	0	0	0	(1,272,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	49,799	143,924	1,256	0	0	0	0	0	0	0	0	194,979	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,331)	150,924	(10,082)	0	0	0	0	0	0	0	0	87,511	45

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Eli Pick	32.50%	N/A		Ballard Partners	Des Plaines Il	Bldg Ownership
Moshe Pick	35.00%			Pick Management Group		Mgmt Company
Hadassah Pick	20.00%					
Sarah Fitterman	10.00%					
Gloria Pruzan	2.50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,272,000	BALLARD PARTNERS		$	$ (1,272,000)	1
2	V								2
3	V	19	ACCOUNTING		BALLARD PARTNERS		7,000	7,000	3
4	V	30	DEPRECIATION		" " "		404,880	404,880	4
5	V	32	INTEREST		" " "		679,045	679,045	5
6	V	33	REAL ESTATE TAX		" " "		331,999	331,999	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,272,000			$ 1,422,924	$ * 150,924	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 158,500	PICK MANAGEMENT	100.00%	$	$ (158,500)	15
16	V								16
17	V	17	SALARIES		" " "		134,115	134,115	17
18	V				" " "				18
19	V	19	DATA PROCESSING		" " "		967	967	19
20	V	21	OFFICE EXPENSE		" " "		44	44	20
21	V	27	PAYROLL TAXES		" " "		12,036	12,036	21
22	V	30	DEPRECIATION		" " "		1,256	1,256	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 158,500			$ 148,418	$ * (10,082)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MOSHE PICK	EXEC DIRECTOR	ADMIN	35.00	NONE	40	100.00	SALARY	$ 66,406	17-7	1
2	ELI PICK	EXEC DIRECTOR	ADMIN	32.50	NONE	40	100.00	SALARY	66,406	17-7	2
3	HADASSAH PICK			20.00				SALARY	1,302	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 134,114		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ALLFIRST		X	MORTGAGE	$44,927.00	5/91	$ 4,500,000	$	8/34	10.5000	$ 679,045	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL							71,223	6
7	CAPITALIZE LEASES		X	EQUIPMENT							9,858	7
8	INSURANCE FINANCING		X	INSURANCE							3,441	8
9	TOTAL Facility Related				$44,927.00		$ 4,500,000	$			$ 763,567	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,500,000	$			$ 763,567	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 368,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 346,499	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21,501)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 353,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 331,999	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	335,298	8
	1998	352,039	9
	1999	355,679	10
	2000	360,457	11
	2001	346,499	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALLARD NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023093

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	NURSING HOME	$ 346,498.85	$ 346,498.85
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 346,498.85	$ 346,498.85

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 770,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1991	1973	$ 2,851,196	$ 96,557	35	$ 90,514	$ (6,043)	$ 1,096,267	4
5				1994	995,072	25,515	35	25,515		220,067	5
6				1994	986,459	25,294	35	25,294		205,514	6
7				1995	101,526	2,603	35	2,603		19,631	7
8											8
	Improvement Type**										
9	VARIOUS			1980	2,955		20			2,947	9
10	VARIOUS			1981	11,619		20			11,558	10
11	VARIOUS			1982	17,413		20			17,408	11
12	VARIOUS			1984	3,536		20			3,536	12
13	VARIOUS			1985	8,040		20			8,040	13
14	VARIOUS			1986	18,668		20	983	983	16,218	14
15	VARIOUS			1987	42,109	722	20	1,413	691	41,106	15
16	VARIOUS			1988	15,834	350	20	373	23	14,457	16
17	VARIOUS			1990	4,990	158	20	250	92	3,188	17
18	VARIOUS			1991	155,172	7,257	20	8,760	1,503	100,470	18
19	VARIOUS			1992	54,689	1,274	20	2,734	1,460	28,509	19
20	VARIOUS			1993	1,571	50	20	77	27	751	20
21	HEATING COOLING SYSTEM			1996	2,312	59	20	116	57	764	21
22	INTERIOR SIGNS			1996	350	9	20	18	9	118	22
23	BUILDING IMPROVEMENT			1996	70,114	1,798	20	3,506	1,708	23,081	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR SYSTEM BALANCE	1996	$ 1,762	$ 341	20	$ 88	$ (253)	$ 579	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	658	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	217	39
40	DRAPES	1996	616	16	20	31	15	204	40
41	COMP STATION CABLE	1996	2,566	491	20	128	(363)	843	41
42	HEAT AND COOLING SYSTEM	1997	2,999		20	150	150	800	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	708	43
44	CAULKING	1998	5,845	150	20	292	142	1,217	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	1,382	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	486	46
47	PARKING LOT	1998		51	20		(51)		47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	615	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	625	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	677	50
51	PATIO FLOOR	1998	2,040	52	20	102	50	451	51
52	MOTOR	1998	1,544	40	20	77	37	372	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	773	53
54	FAUCETS, COUPLINGS	1998	10,159	762	20	508	(254)	2,286	54
55	COMPRESSOR	1998	13,886	356	20	694	338	3,007	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	23,363	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	39,500	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	13,999	58
59	AIR CARRIER	1999	693	18	20	35	17	108	59
60	CARPETING	1999	4,921	126	20	492	366	1,927	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	23,846	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	477	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	1,298	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	323	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	2,272	65
66	DOOR CENSORS	1999	718	18	20	36	18	123	66
67	SIGNS	1999	18,235	468	20	912	444	3,344	67
68	METAL ENCLOSURE	1999	934	24	20	47	23	141	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	11,799	69
70	TOTAL (lines 4 thru 69)		$ 6,055,069	$ 181,084		$ 197,962	$ 16,878	$ 1,952,050	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,055,069	$ 181,084		$ 197,962	$ 16,878	$ 1,952,050	1
2	NURSE CALL SYSTEM	1999	49,222	1,055	20	2,461	1,406	8,819	2
3	LOAD RAMP-DESIGN	1999	14,368	368	20	718	350	2,693	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	463	4
5	FIRE PANEL	1999	978	25	20	49	24	176	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	6,973	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	178	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	886	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	616	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	2,941	10
11	HOT WATER BOILER	2000	9,172	259	20	459	200	765	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	59,367	20	4,169	(55,198)	43,080	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	892	10	172	(720)	516	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	49,896	16
17									17
18	DIALYSIS SPACE/MEDICAL & GAS UPGRADES	2001	33,596	1,058	27.5	1,221	163	1,866	18
19	COOLING COIL REPLACEMENT	2001	24,604	1,058	27.5	895	(163)	1,380	19
20									20
21	BUILDING IMPROVEMENTS	2002	114,570	2,250	20	5,728	3,478	5,728	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,552,635	$ 251,671		$ 219,681	$ (31,990)	$ 2,079,026	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 204,989	$ 60,324	$ 20,499	$ (39,825)	10	$ 40,295	71
72	Current Year Purchases	263,397	115,895	26,339	(89,556)	10	26,339	72
73	Fully Depreciated Assets	93,318				10	93,318	73
74	RELATED PARTY	2,172,927		217,293	217,293		443,095	74
75	TOTALS	$ 2,734,631	$ 176,219	$ 264,131	$ 87,912		$ 603,047	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,287,266	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 427,890	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 483,812	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,922	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,682,073	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 30,229 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service	Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 29,188	$		$ 29,188	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,540			3,540	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			70,000			70,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				279,642		279,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2 & 3					591,478		591,478	13
14	TOTAL			$		$ 102,728	$ 871,120		$ 973,848	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 148,000)	2,851,710		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	195,685		6
7	Other Prepaid Expenses	74,366		7
8	Accounts Receivable (owners or related parties)	656,362		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,778,123	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	291,277		16
17	Accumulated Depreciation (book methods)	(261,390)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LEASE DEPOSITS	23,378		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 53,265	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,831,388	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,364,511	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,729		28
29	Short-Term Notes Payable	863,358		29
30	Accrued Salaries Payable	347,286		30
31	Accrued Taxes Payable (excluding real estate taxes)	82,931		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Lease payable	67,468		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,754,283	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,094,384		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,094,384	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,848,667	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (17,279)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,831,388	$	48

*(See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (344,533)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (344,533)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	327,254	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 327,254	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (17,279)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,417,166	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,417,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	569,676	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 569,676	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,681	13
14	Non-Patient Meals	2,146	14
15	Telephone, Television and Radio	7,826	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 17,653	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,123	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,123	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	2,302	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,302	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,012,920	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,253,030	31
32	Health Care	4,793,430	32
33	General Administration	2,096,016	33
	B. Capital Expense		
34	Ownership	1,442,857	34
	C. Ancillary Expense		
35	Special Cost Centers	973,848	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,685,654	40
41	**Income before Income Taxes (line 30 minus line 40)****	327,266	41
42	**Income Taxes**	(12)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 327,254	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,534	2,688	$ 84,760	$ 31.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,161	26,136	769,798	29.45	3
4	Licensed Practical Nurses	33,066	37,283	499,917	13.41	4
5	Nurse Aides & Orderlies	104,965	113,712	1,422,564	12.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	29,383	30,839	969,986	31.45	7
8	Rehab/Therapy Aides	3,800	4,000	48,965	12.24	8
9	Activity Director	1,686	1,759	25,716	14.62	9
10	Activity Assistants	12,122	13,085	112,016	8.56	10
11	Social Service Workers	5,464	6,221	91,564	14.72	11
12	Dietician					12
13	Food Service Supervisor	2,703	3,115	54,085	17.36	13
14	Head Cook	1,952	2,053	20,745	10.10	14
15	Cook Helpers/Assistants	16,017	17,374	124,490	7.17	15
16	Dishwashers	8,701	9,197	61,213	6.66	16
17	Maintenance Workers	4,458	4,839	85,650	17.70	17
18	Housekeepers	32,312	34,536	214,124	6.20	18
19	Laundry	8,266	9,546	79,797	8.36	19
20	Administrator					20
21	Assistant Administrator	1,925	2,086	112,984	54.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,605	32,431	520,424	16.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,988	2,132	20,906	9.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	327,108	353,032	$ 5,319,704 *	$ 15.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,850	1-3	35
36	Medical Director	O	81,100	9-3	36
37	Medical Records Consultant	N	4,128	10-3	37
38	Nurse Consultant	T	24,316	10-3	38
39	Pharmacist Consultant	H	8,580	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		250	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,170	11-3	44
45	Social Service Consultant	E	6,753	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 134,147		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,921	$ 175,618	10-3	50
51	Licensed Practical Nurses	4,782	215,324	10-3	51
52	Nurse Aides	484	4,842	10-3	52
53	TOTAL (lines 50 - 52)	10,187	$ 395,784		53

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMIN		$ 0
SUE MIKALS	ASST ADMIN		112,984
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,984

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 158,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 158,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		86,939
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 86,939

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,586
Unemployment Compensation Insurance	41,906
FICA Taxes	384,763
Employee Health Insurance	225,285
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,064
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	1,716
INSURANCE - EXECUTIVE LIFE VI 21	(1,716)
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	25,747
Health Care Worker Background Check	2,980
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	44,627
TRUST/FRANCHISE/CONTRIB/ETC	8,420
LICENSES & PERMITS	7,186
DUES & SUBSCRIPTIONS	12,461
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(8,420)
Less: Public Relations Expense	(0)
Non-allowable advertising	(44,627)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,053
Seminar Expense	
	8,193
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,246

**See instructions.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL COUNC ON LONG TERM CARE $4020

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 6,399 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 126,473
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ #REF! Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BALLARD NURSING CENTER **#0023093** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,850	
	REPAIRS & MAINTENANCE		0	
			0	7,850
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		59,067	
	ELECTRICITY		91,888	
	WATER		46,937	
	CABLE TV - LOBBY		2,056	
			0	199,948
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,145	
	PAINTING & DECORATING			
	BUILDING REPAIRS		0	
	CONTRACTED BLDG MAINT		20,612	
	EQUIPMENT MAINTENANCE & REPAIR		51,717	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE			
	FIRE SERVICE		0	
			0	
			0	81,474
7	**OTHER**			
	SCAVENGER & EXTERMINATOR		26,783	
	SECURITY SERVICE		0	26,783
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	81,100	81,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	395,784	
	LABORATORY & XRAY EXPENSE		16,835	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	8,580	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	24,316	
			0	
			0	449,643
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		9,911	
	SPEECH THERAPY SERVICES		5,226	
	OCCUPATIONAL THERAPY SERVICES		6,575	
	REHABILITATION CONSULTANT	XVIII B __-2	35,986	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	250	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	57,948
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,170	
				1,170
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,753	
			0	6,753
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BALLARD NURSING CENTER **#0023093** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		14,326	14,326
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	158,500	158,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	42,180	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	44,759	
			0	86,939
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	44,627	
	EMPLOYEE WANT ADS	XIX F	25,747	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	12,461	
	LICENSES & PERMITS	XIX F	7,186	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,020	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,980	101,421
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		6,788	
	EQUIPMENT REPAIR & MAINTENANCE			
	OUTSIDE CLERICAL SERVICES			
	PENALTIES	VI 18	1,018	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		88,556	
	MESSENGER SERVICE		0	
	COMPUTER EXPENSE		23,545	119,907

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	384,763	
	UNEMPLOYMENT COMPENSATION	XIX D	41,906	
	WORKERS COMPENSATION INSURANC	XIX D	47,586	
	HOSPITALIZATION INSURANCE	XIX D	225,285	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,064	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,716	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	712,320
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	8,193	
	TRAVEL	XIX G	7,053	
			0	
			0	15,246
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		146,624	146,624
27	**OTHER**			
	BAD DEBTS	VI 24	22,142	
			0	22,142

GRAND TOTAL COLUMN 3 OTHER 2,290,094